Michigan's Long Term Care Workgroup's Recommendations (Summary by Brenda Schmitthenner)

The state of Michigan began working on a three-year plan in 1998 to improve services to the elderly in the state. The state's goals included: improvement in accessibility, availability, and affordability of health and LTC, improvement in the nutritional condition of the elderly, improvement in accessibility to programs and services, improvement in the mobility of the aged, improvement in employment opportunities for older persons, improvement in volunteer opportunities for the aged, development of a continuum of housing options for seniors, protection and promotion of the rights and independence of seniors, and lastly, fostering of a positive public understanding about the contributions, needs and problems of seniors through the design and implementation of a comprehensive information system. From these goals emerged the LTC Workgroup.

In September 1999, the LTC Workgroup produced a preliminary report and recommendations. They spent over a year evaluating what other states had done to create an organized and managed service delivery system which would improve access to LTC services, increase consumer choice and control costs. They determined that there is not one clearly preferable approach. They recommended that rather than selecting one model, the state should try multiple models in various settings in phase one. During 2000, they recommended that Michigan use five different models: PACE model, Care Coordination, LTC HMO, Regional Provider Organization and Virtual Organization, to provide an integrated LTC delivery system. Each of the models would include: ability of persons not covered by Medicaid to purchase the LTC plan, maximize opportunities for public-private funding partnership, offer one-stop shopping, provide a commitment to

consumer choice and satisfaction, focus on quality of life and care, be cost-effective and budget neutral, use capitated funding, provide comprehensive services and supports, financial risk would be incurred by managing entity, include use of contemporary technology, provide integration of multiple revenue sources into one delivery system to meet all LTC needs, provide easy access for consumers, and lastly, insure that vendors are paid in a timely manner. Each of the models is designed to interact with the Medicaid statewide program for information, assessment, evaluation and enrollment. Each model would be tested with two to three large scale projects, have 1,000 or more participants at each site and include both rural and urban areas. After implementation, each model will be evaluated on the extent that the model achieved the intended outcomes and also which model or models function best in certain situations, eg. urban vs. rural.

MODEL 1 - PACE

The PACE model was designed to replicate the project currently in place at the Henry ford Health System in Detroit. It is the only current model that is approved by HCFA that integrates both Medicare and Medicaid funding. PACE services individuals in day centers, clinics, homes, hospitals and SNFs. It integrates acute and LTC services in an adult day health care model. The objective of the PACE model is to provide total care to participants in a seamless system to prevent unnecessary use of hospital and nursing care. The enrollment focus is on those who are 55 or older, eligible for care in a SNF, live in the program's defined geographical area, and are eligible for both Medicare and Medicaid benefits. Participants who are not eligible for Medicaid must pay privately for that portion of their monthly fee (about $2,183). Once enrolled, a participant can

receive services only from PACE staff or contract providers authorized by PACE staff. There will be three PACE projects in phase one. At least one will be a rural site.

Services provided through the PACE model are comprehensive, use an interdisciplinary team for case management and integrate primary and specialty medical care. Primary care physicians are key members of the ID team. The ID team is at the heart of the model. They provide care planning, service authorization, monitoring, and advocacy. All participants in this model have access to day center sites that can accommodate between 120-150 individuals, are open 5 to 7 days per week and offer a full service medical clinic. Transportation to the centers is included. Behavioral health services are included in the services provided by this model and preventive health care is the primary focus.

PACE will receive monthly capitations from both Medicare and Medicaid. The Medicare portion of the capitation is currently based on the average area per-capita cost methodology used to reimburse Medicare HMOs. The Medicaid capitation is negotiated between the Dept. of Community Health and the program provider. Michigan currently sets its capitation rate at 95% of the costs that it pays for a comparable frail elderly LTC population.

In PACE, primary administration is the provider's responsibility. The type of entity that can become a PACE provider varies, but the model tends to reinforce large corporate organizations, such as existing healthcare systems because of the full-risk exposure and the requirements to address all acute and health care needs of all participants.

There are numerous perceived strengths of this model. The case management is comprehensive, it ties acute and LTC management to one entity, it is continuous across settings and it is multi-disciplinary with the physician being key to the case management process. This results in proactive prevention and intervention and reduces the use of more expensive services. The outcomes from this model are well documented. They include: enrollment growth, high level of customer satisfaction, reduced use of institutional and inpatient care, reduced use of drug benefits, reduced use of medical specialists, and effective service and support to frail, elderly individuals with no increase in mortality.

The perceived limitations of the model include: it doesn't address the needs of younger individuals with long-term disabilities, the startup requires substantial time and capital, there is a relationship loss of the senior with existing physician and healthcare professionals, there is limited attraction to model for middle-income seniors who don't qualify for Medicaid and thus, have to pay out-of-pocket for services, the model has experienced difficulty attracting primary care physicians and healthcare professionals, and an entity wishing to become a PACE provider must invest considerable resources before the project begins**.**

Model 2 – Care Coordination Model

This model represents an evolution of the current Medicaid wavier program into a fully developed coordination model. It unites the basic components of managed LTC by building upon the existing LTC infrastructure in Michigan. An existing wavier agent called a care coordinating agent (CCA) is responsible for screening and medical

eligibility determination. Coordination will be achieved through the active involvement of the CCA with the consumer to develop and implement treatment and care plans. The consumer's physician directs acute and primary care activity while the consumer directs the LTC activity. The CCA care manager is involved with both parties as a coordinating agent to advise, monitor and initiate redirection of care and treatment plans when appropriate.

The objective of this model is to demonstrate a non-medical approach to health and LTC services. Seniors who do not meet Medicaid financial eligibility criteria will be directed to a state-funded community case management program for assistance. This model will serve disabled adults 18 and older and elderly 65 and older who are eligible for SNF placement and who reside within the defined service area. Participation in this model is voluntary. This model can be used in either a rural or urban setting and will be implemented in only one site during the first phase.

For administration and management purposes, the CCA must be an existing Medicaid wavier agent capable of bearing full financial risk for Medicaid funded LTC services. Revenue is primarily from Medicaid and Medicare but other funds like local and private funds could be accessed as needed to meet unmet needs. Financing is budget-neutral within the Medicaid LTC program. Medicaid-funded LTC services, both community and facility-based, will eventually be provided on a capitated basis. Medicare and Medicaid-funded health care will continue to be provided on a fee-for-service basis. Community services will be delivered through a competitive provider pool. This broad based provider pool enables the CCA to maximize the benefits of market-driven conditions and secure quality services at the lowest cost.

The perceived benefits of this model include: a full range of existing Medicaid benefits to participants, these benefits are expanded to include service provisions in assisted living and other creative-living environments, the development of volunteer services and a LTC prevention initiative, the development of a quality improvement plan, and the development of a nursing home relocation initiative for nursing home residents who wish to return to a community setting, and lastly, Medicare services are coordinated by the CCA case manager.

The CCA provides case management, follow-up, and monitoring on an ongoing basis. The CM and participant will establish goals and desired outcomes. The CM will maintain contact with the participant through in-home reassessments conducted every 90 days or upon significant changes in condition to ensure the participant's health and safety in the setting of his or her choice. The CM can direct an intervention at any time that a participant fails to progress as expected. The CCA will monitor and report on quality outcomes using MDS-based outcomes assessment systems.

Model 3 – LTC HMO

This model is based on the Arizona and Texas Star+Plus programs. The model seeks to integrate acute and LTC services through delivery by an HMO. This model is targeted at the dually eligible population, those individuals who are eligible for both Medicare and Medicaid benefits. Those seniors that are eligible for Medicare only can purchase this HMO to provide LTC insurance. Medicaid enrollees must participate in this model but dually eligible will be encouraged to obtain Medicare services through the HMO as well. For those who don't wish to receive their Medicare services through the

HMO, there will be a coordination of those services and LTC services by the HMO. The model sites will be in a major metropolitan area with adjoining rural areas. At least two HMOs will service the geographic region.

The HMO will be responsible for assessment, care planning, case management, and service delivery. Telephone contact will be made within 24 hrs. of referral and an in-person contact will take place within 48hrs. of referral. The HMO will use case management techniques including assessment, monitoring, targeted care managed for high cost of high-needs cases and will utilize modern information technology. Care plans will be person-centered and monitoring will be conducted at required intervals. The HMO must create a strong link with aging services without creating overlaps in responsibilities.

Capitation creates strong incentives for cost containment. The HMO will be at risk for costs. There will be some risk-sharing strategies in the first year of operation. The capitation payment to the HMO will be based on regional fee-for-service costs for individuals needing LTC services. The HMO will be paid a fixed per-member, per-month, case mix-adjusted rate for all Medicaid participants that are receiving services. HCFA would pay the capitated rate for Medicare recipients that choose to receive their Medicare services through the HMO also. For those dually eligible participants that are also receiving LTC services through the HMO, a separate rate would be paid by Medicaid for these LTC services in addition to the HCFA payment for Medicare services.

Model 4 – Regional Provider Organization (RPO)

This model is a partnership among multiple provider organizations to form a single integrated service delivery system. It applies managed care principles of risk and capitation to a provider-driven alliance. It allows the flexibility necessary to accommodate changing community needs. The partnership would make adjustments to meet the changing needs of the customers. Each RPO will be distinct in its organization. Participating organizations will include the area agency on aging, skilled or basic-care nursing facilities, primary care physicians, hospital systems, local health departments, home care agencies, community mental health programs, assisted living residences and other organizations identified by the community to meet the needs of the consumers. The model is community-based and is built upon resources that are already available within the system. It is a structured effort to organize and expand the availability and quality of informal services and supports. The service provider network would be linked by a compatible information and communication system. This model would test whether a partnership arrangement among existing providers could positively impact public spending for acute and LTC services.

To participate in the RPO model, seniors would have to be Medicaid eligible or be willing to participate on private pay or sliding fee scale basis. Participation would be voluntary for existing Medicaid recipients but would be mandatory for new recipients. Coordination of Medicare services would be voluntary. The RPO program would serve disabled adults 18 or older and seniors 65 and older who have a need for LTC services. Participants would have to reside within the defined service area. This model will be

tested in a variety of settings, both urban and rural, and within single and multiple-county service areas.

The structure and composition of the administrative entity will be flexible. The partnership will be a legal entity that can bear risk and meet provider service organization requirements. It will assume full risk. Financing of the RPO will begin in a fee-for-service environment. Concurrently, the state of Michigan will conduct an analysis on fee-for-service costs in the defined service area and develop capitated projections. This cost and capitation analysis will incorporate case mix and other adjustments such as age, gender, and geographical area of residence. Eventually, payment would be on a per-member, per-month basis. As the RPO grows into a full managed care entity, risk sharing will be shared among all partners in a manner decided on by the partnership. Coordination of care services will result in desired savings and cost controls.

Information collected during the telephone and in-home assessment will serve as the building block for further assessment and care planning by the RPO. The assigned RPO case manager will coordinate access to all services within the plan. There will be timely access to services. The RPO will assign a case management team for each participant. The team is developed according to the participants needs and preferences. The CM and participant develop a single plan of care, which coordinates all aspects of service delivery. The participant must approve the care plan prior to implementation. Case managers arrange and purchase all services from the participant's providers of choice. The assigned case managers will provide case management, follow-up and

monitoring on an on-going basis. The CM will maintain contact with the participant with in-home assessments conducted every 90 days.

Model 5 – The Virtual Organization

The VO model is characterized by electronic communication linking together components of a corporation, or partner corporations, to respond to market opportunities. This model allows for great flexibility and partnerships and work arrangements that are not bound by geographic considerations. Local agencies and businesses will form the basis of the virtual organization and will receive infrastructure support and ongoing technical assistance from the state. The development of the VO is a two-step process. It begins with the design of the business model followed by the design of the supporting information resources. A critical element in this model is fast communication technology that: captures and shares assessment information, provides information on existing services and providers, makes available care plan status and other information exchanges, provides email, makes electronic payment for services, distributes financial risk to partners, provides security that protects consumer's information and enables the assessment of the quality of services provided. Information must flow in the following manner: information on needs determined by assessment and customer preference must be captured and stored in the system, information must then flow to the persons seeking LTC services as feedback and new information about what services are available and where they can be obtained, and finally, the information needs to be shared with appropriate virtual partners so that the consumer would not have to provide identical information repeatedly to different agencies. The VO would use a voucher system, thus

giving control to the consumer for services received. The VO model would focus on the use of modern technology to link together providers, consumers, payers and regulators in one system that shares information and organizes service delivery and payment.

Elderly over age 60 and disabled adults over age 18 could participate in the VO model. It would be mandatory for new Medicaid enrollees but voluntary for those individuals who are existing beneficiaries. Medicaid LTC financial and medical eligibility would not be changed by this system. The funds for this model would come from Medicaid, aging services, local funding, LTC insurance, and private funds. Medicare would also fund the model if the federal wavier were approved. Rate determination initially will continue as it is done presently. Eventually, the VO will be put on a global budget and on a risk-bearing capitated payment. Initially, payment will be given to participating partners in the VO. Over time, payment will be made to the VO structure, which will emerge as a managed care organization. Once global budgets and capitation are in place, increases will be carefully limited to a rate discounted by the savings implicit in the managed care market.

The VO will have an advisory council comprised of at lest 50% consumers. Initially, administration for the VO model will be centered in a single organization with multiple responsibilities including coordination of services. This single organization will collaborate with other organizations. It will create a team-oriented culture. Contracting and formal partnership agreements will formalize network and information-sharing relationships. Referrals will come to the VO. One of the partners in the VO will be responsible for the initial comprehensive assessment. During the case management process a person-centered care plan would be developed and implemented. This

assessment and care plan would be shared electronically with the participant and the providers of service to ensure overall understanding, consistency and uniformity in the care process. Regular outcome evaluation and revisions would be part of the assessment process. This would take place at three-month intervals or when there was a significant change in the participant's status.

Based on the review of the five models that will be tried in Michigan in phase one, it will be interesting to see which counties and communities choose which model and also which model is most successful with regard to case management, cost effectiveness and consumer appeal. Hopefully, a review of all models will be published after the first year of operation.

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